# ENROLLMENT /COVERED FUNCTION ISSUE

A gray area has developed around the applicability of the enrollment transaction to some of DSHS' programs.

## Questions and Short Answers:

(1) Does the enrollment transaction occur now in the "social service" parts of the health plan?

Not Always.

(2) Medicaid conducts the enrollment function for its clients and must have electronic HIPAA compliant enrollment capability. DSHS is one health plan. Does this mean all parts of the health plan must conduct enrollment?

It means that the MMIS must be sent the enrollment data for all clients eligible to receive "plan" services.

(3) Whether or nor enrollment is conducted, the health plan must respond to provider eligibility inquiries and adjudicate required HIPAA-compliant claims, claim status, prior authorization, and remittance advice transactions. If the enrollment data is not contained in the capacity payment system, what system(s) will support the eligibility transaction?

All enrollment data must be in the capacity system for claims and other transactions. Other systems may also need to contain this information.

## Background:

HIPAA defines enrollment as the transmission of subscriber enrollment information to a health plan to establish or terminate insurance coverage. This transaction supports transfer of enrollment and maintenance information from the sponsor of the insurance coverage, benefit, or policy to a payer (health plan). The transfer may be within the same entity or to another entity.

In a typical health care situation or "medical model" this transfer occurs when:

a) an employer sends enrollment information to a health plan to initiate or discontinue insurance coverage for its employees, or
b) CSOs determine TANF client's financial eligibility for Medicaid and send eligible client information to Medicaid (see exception below).
c) Other contracted or block grant entity (such as an RSN, local health department, provider or county) determines eligibility and sends eligible client information to Medicaid.
d) Medicaid sends enrollment information to its managed care plan to initiate or discontinue insurance coverage for Medicaid clients.

## Issue:

Many social service programs do not have a distinct "plan" that eligible clients are "enrolled" in. Thus, two questions arise:

1. what is the “coverage, benefit, or policy” that a social service client is enrolled in, and
2. at what step in the process is enrollment, as defined in HIPAA, accomplished.

Some social service programs within DSHS follow these steps:

First, determine if a person is qualified for services offered by that program;
Second, determine (often with client input) which set of services or benefits offered by the program suits the client’s needs;
Third, send the client and service specific information to a payment system.

Case 1 Description: Children’s Administration pays for Behavioral Rehabilitation Services and Therapeutic Child Development. A DSHS employee (social worker or nurse) is responsible for determining medical necessity. If the service is “necessary” the employee would inform SSPS that the care is authorized and okay the bill to be paid. The provider bills SSPS.

Case 2 Description: Aging pays for residential care. A DSHS employee (case manager) determines whether the client has an impairment, and the functional status of the client in a case assessment. Then, the specific type of residential care facility would be selected. The client would be placed in the facility and information about the placement would be sent to SSPS or MMIS, depending on the type of facility. The facility bills the relevant payment system.

In each case, what is the “plan” that the client is enrolled in–

- is it the specific benefit or service they were authorized for,
- is it the whole range of services provided by that program, or
- is it a subset of those services?

If the client is enrolled at the last stage in an individualized “plan”, then the transfer of information from the program to the payment system is an enrollment transaction under HIPAA.

If the client is enrolled at an earlier stage in the program’s plan, or a subset, then there may be no enrollment “transaction” as defined in HIPAA. There are business processes conducted by health plans, government plans especially, that do not fit the exact definition of the transactions in the regulation.

The reason there would be no transaction here is because there is never a transmission of information, or transaction, to initiate the coverage. The same person that determined eligibility and initiated the coverage, also administers the benefit and did not transmit the information until later when actually selecting a service under the benefit plan. However, it is important to note here, that the information contained in an enrollment transaction must still be transmitted to the

payment system in order for the system to be capable of performing other HIPAA required transactions such as responding to eligibility inquiries, prior authorization, or paying claims.

**Analysis**:

Definitions. HIPAA defines a health plan as any group or individual that pays or provides the cost of medical care. HIPAA defines a sponsor in the implementation guides as the party ultimately pays for the coverage, benefit, or product.

Transaction Roles. Sponsors send enrollment information and premium payments to the health plan. Health plans accept the enrollment and premium payments. Health plans, in turn, accept and respond to health care provider inquiries about eligibility, prior authorization and referrals, and the health plan accepts claims, responds to claims status inquiries, and sends remittance advices.

HIPAA Requirements. Section 1171(5)(E) of the Social Security Act, as enacted by HIPAA, identifies the State Medicaid programs as health plans, which therefore must be capable of receiving, processing, and sending standard transactions electronically. There is no requirement that internal information systems maintain data in accordance with the standards. However, Medicaid programs will need the capacity to process standard claim, encounter, enrollment, eligibility, remittance advice, and other transactions. (FAQ quote).

Official Comments exception: …we do not consider an agency that is not otherwise a covered entity, such as a local welfare agency, to be a covered entity because it determines eligibility or enrollment or collects enrollment information as authorized by law. We also do not consider the agency to be a business associate when conducting these functions.

Thus, HIPAA requires health plans, including Medicaid, to have the capacity to conduct enrollment transactions (when acting in a sponsor capacity). However, not every entity that sends enrollment information must comply with the standard (such as employers).

Capacity System: DSHS conducts enrollment on behalf of clients enrolled in Medicaid. DSHS has decided that all of the programs that perform health plan functions are part of one DSHS health plan. Thus, DSHS must have the capacity to conduct electronic enrollment in a HIPAA compliant way.

Additional systems: Other payment systems within DSHS would not be required to conduct electronic enrollment. However, those systems that do conduct enrollment must do so in a HIPAA compliant way. Additionally, if another system does not conduct enrollment, then it would not be able to respond to "linked" HIPAA transactions, such as eligibility inquiries.

Internal Impact: The impact of standardizing internal enrollment communications is fairly minimal. DSHS can use the direct data entry mode to comply with the standardized content, but not have to comply with the standardized format.

Discussions are already under way with the ACES system owners about what content change might be necessary because most of the enrollment data originates there.

One solution that supports this model is using the HIPAA enrollment transaction supplemented with the ANSI X12 unsolicited 278 (which is standardized, but is not a HIPAA required transaction) to send both the health plan and the treatment plan – which is service specific – to an enrollment file. This can be used to respond to 270 –Eligibility – and 278 – Prior Authorization – inquiries, as well as feed the needed data to adjudicate HIPAA claims and conduct the other, above named, HIPAA-required transactions.

External Impact: Enrollment data is used to respond to claims and to respond to inquiries from providers about client eligibility and prior authorization. Because these transactions are "linked", the system that contains the enrollment data is also the system that must respond to these inquiries. Providers need to be educated about where to route their inquiries.

**Decisions and Consequences:**

If the coverage is defined at a specific, individual benefit or service level, then each change of services equals an enrollment or dis-enrollment. This would be a significant increase in the amount of HIPAA covered transactions conducted within DSHS.

If the coverage is defined at a more general level with multiple service options within that "plan" (ie. Aging Plan or the "Aging Residential Plan"), then the client is enrolled at the program level. In this scenario enrollment data is not transmitted to another part of the agency because the case manager acts as in multiple roles. However, programs must still transmit the data contained in the enrollment transactions so that the capacity system can respond to provider inquiries.

Additionally, other transactions that the plan must be capable of sending or receiving, and that are linked or dependent on enrollment data, will need to be reviewed. These include eligibility and prior authorization transactions, as well as claims and payment and remittance advice.

One way to conceptualize this is using the analogy to the Workers' Compensation health care delivery model where the injured worker is enrolled in Workers' Compensation and authorized for a treatment plan specific to the injury. One solution that supports this model is using the HIPAA enrollment transaction supplemented with the ANSI X12 unsolicited 278 (which is not a HIPAA required transaction) to send both the health plan and the treatment plan – which is service specific – to an enrollment file. This can be used to respond to 270 –

Eligibility and 278 – Prior Authorization inquiries, as well as feed the needed data to adjudicate HIPAA claims and conduct the other HIPAA-required transactions.

More detail on proposed solutions is available in the Enrollment Solutions proposal document being developed by the MAA project.

## POLICY TAG DISCUSSION:

Most Policy TAG members feel that their administration's business model is more analogous to an enrollment model at a program level. The specific services that the client is authorized to receive are similar to an individual treatment plan similar to a medical or mental health provider may develop.

Thus, most members identify the process of "enrollment" as occurring at the administration or program level. The secondary process of determining the specific service or services to be provided is viewed by the members as part of treating or assessing the client's "health" needs, just as a primary care physician might do in a traditional medical model.

Practical implications: Under this scenario, the administrations do not conduct the HIPAA Enrollment Transaction when the same person receives the client information, makes the program level determination, and then makes more individualized service determinations. This is because information is not transmitted to a part of the DSHS health plan for the purpose of initiating coverage.
As noted in the handout, the health plan must still respond to other HIPAA defined transactions that are dependent on the enrollment data. Therefore, the enrollment data still needs to be sent to the appropriate part of the health plan that initiates or responds to these transactions.